DECLARATION OF

LISA DeROCHE

EXHIBIT D

REQUEST FOR FAMILY MEDICAL LEAVE, PERSONAL LEAVE OR EXTENDED LEAVE
This leave is designated as leave granted pursuant to the Family and Medical Leave Act (FMLA)

Name: Lizbeth Augustine **Emp ID:** E05107
Department: Customer Marketing Group
Manager: Cynthia Starr **Telephone:** 212 314-2906
Type of Leave (Disability, Family Medical Leave, Personal Leave of Absence): Family Leave
Paid Time Off (Accrued and Unused) to be used 0 Days
Last Day Worked: _____

Duration of Leave of Absence

Sick Days	Start_____ End_____
Short Term Disability (STD)	Start_____ End_____
Paid Time Off (PTO Days)* *Must be approved by your Manager*	Start_____ End_____
Unpaid Family Medical Leave of Absence * *Must be approved by your Manager for Leaves greater than 12 weeks (including paid sick days, STD and PTO days)*	Start_____ End_____
Intermittent Family Medical Leave *Pending medical certification if applicable*	Start 12/21/06 End 4/15/07 Weekly Schedule: 3 days in Regaffic 2 Days after
Transition-Time/Medical Reduced Schedule* *Must be approved by your Manager*	Start_____ End_____ Weekly Schedule:_____
Personal Leave of Absence** *Must be approved by your Manager and Sr. Vice President*	Start_____ End_____

Expected Full Time Return to Work Date _____

*** Approved by Manager:** _____ **Date:** _____

****Approved by Sr. Vice President:** _____ **Date:** _____

GROUP INSURANCE BENEFIT ELECTION DURING LEAVE OF ABSENCE

✓ **I elect to continue** my Group Insurance coverages in force prior to my leave of absence, with the exception of Disability Pay Plans, and I agree to pay the necessary monthly contribution required by this Election. I understand that these contributions are due and payable no later than the last day of the month in which they are due. If this amount is not paid by such date, my Group Insurance coverages will terminate.

_____ **I elect NOT to continue** my Group Insurance coverages during my leave of absence.

Signature LAugustine **Date:** 12/14/06

Home Address 9 Painted Wagon Rd Holmdel NJ 07733
Number and Street Address City or Town State Zip Code

12/15/05

Return Form to: AXA Financial
Corporate Benefits
100 Madison Street, MD 33-3
Syracuse, NY 13202
FAX: 315-477-3364

12/13/2006 WED 14:05 FAX 2123142199 IMCG

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

*(When completed, this form goes to the employee, **Not to the Department of Labor.**)*

OMB No.: 1215-0181
Expires: 07/31/07

1. Employee's Name: LIZ AUGUSTINE

2. Patient's Name *(if different from employee)*: MEGAN McEVOY

3. Page 4 describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1) ____ (2) ____ (3) ____ (4) ✓ (5) ____ (6) ✓, or None of the above ____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Six year old with history of juvenile rheumatoid arthritis requiring tracheostomy, recent airway surgery. No longer has tracheostomy but has long term airway and lung changes as ~~a~~ result of condition and treatment

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

commenced 7/05

duration - 5 yrs

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

yes

If yes, give the probable duration: 5 yrs

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

Chronic condition

[1] Here, and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

Form WH-380
Revised December 1998

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

cannot be predicted

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

Patient sees a specialist in pulmonary medicine and a pediatric ENT specialist

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

albuterol inhalation, oxygen as needed antibiotics as needed

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Signature of Health Care Provider

Type of Practice

UPTOWN PEDIATRICS
Ramon J.C. Murphy, MD
John G. Latsen, MD Signe Lowe, MD
Beth Cohen, MD Daniel Cameron, MD
Ivanya L. Alpert, MD
1245 Park Avenue
New York, NY 10128
Tel: 212-427-0540 Fax: 212-534-1086

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Preventative Care - to maintain Health
Specifically during winter months
due to cold virus's etc.

Employee Signature

12/14/06
Date

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider **on at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (1) Requires **periodic visits for treatment** by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (3) May cause episodic rather than a continuing period of incapacity[2] (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment** by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would **likely result in a period of incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 OFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

U.S. GPO: 2000-461-854/55505